Horizon Infusions

Nulojix (belatacept)

Select referral location:

Akron	Cleveland	Dayton (Englewood)
Athens	Columbus (East Broad)	Findlay	Springfield
Canton	Columbus (Hilliard)	Liberty	Toledo
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	Crestview Hills (NKY)
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	Warren

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg

Patient Status: New to therapy   Continuing therapy   Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)
Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

Kidney Transplant (_____)   Other: _____

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

NULOJIX   Initial   Maintenance

Day 1 (*day of transplantation, prior to implantation*) **and Day 5** (*approximately 96 hrs after Day 1 dose*) administer 10 mg/kg IV

Week 2 and Week 4 after transplantation administer 10mg/kg IV

Week 8 and Week 12 after transplantation administer 10mg/kg IV

Maintenance Phase

End of Week 16 after transplantation administer 5mg/kg IV

Every 4 weeks (+/- 3 days) thereafter administer 5mg/kg IV

Vital signs per HI Protocol

Anaphylaxis and Hydration Management per HI Protocol

PRE-MEDICATIONS   N/A
Acetaminophen   500mg   650mg   1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydrimine (Benadryl)   25mg   50mg   PO   IV (requires driver)
Methylprednisolone (Solu-Medrol)   40mg   80mg   125mg IV
Prednisone _____ mg PO
Other _____

POST-MEDICATIONS   N/A
Acetaminophen   500mg   650mg   1000mg
Prednisone _____ mg PO
Other _____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (*specify*): _____
CRP	Each Infusion	Other Frequency (*specify*): _____
CMP	Each Infusion	Other Frequency (*specify*): _____
ESR	Each Infusion	Other Frequency (*specify*): _____
Hepatic Panel	Each Infusion	Other Frequency (*specify*): _____
Renal Panel	Each Infusion	Other Frequency (*specify*): _____

Quantiferon TB Gold, annually, last completed (*date*): _____

Other (*specify*):_____

7. SIGNATURE (required)

_____   _____

PHYSICIAN'S SIGNATURE   **DATE**